NOTICE OF INDEPENDENT REVIEW DECISION

September 11, 2003

MDR Tracking #: M2-03-1529-01-SS
IRO Certificate #:IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient sustained an injury while helping lift a crate off of a truck on ___ and noted immediate back pain radiating down the left lower extremity. An MRI dated 07/24/02 revealed a left disc herniation at L4-5. He underwent a lumbar laminotomy and partial diskectomy at L4-5 on 10/29/02. He returned to limited work on 12/09/02 until 03/2003. He began having increased back pain and was initially treated with anti-inflammatory, muscle relaxant, and analgesic medications and epidural steroid injections. The patient did not receive significant relief from any of these conservative therapies.

Requested Service(s)
Exploration laminectomy, posterior lateral fusion, bone graft iliac crest, and EBT bone stimulator

Decision
It is determined that the proposed exploration laminectomy, posterior lateral fusion, bone graft iliac crest, and EBT bone stimulator are not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
The patient did not have any post-operative physical conditioning or weight reduction programs, trial of bracing, or home exercise program.

In addition, the physical examinations from two different doctors do not agree. One states the straight leg test was positive and the other, that is was negative. Cross-legged test was also in variance. However, both examiners agreed that there was no sensory motor reflex change.

It is possible that the patient's pain is emanating from the L4-5 disc. Provocative discography at the level of previous surgical intervention is generally not considered valid. The MRI does not show evidence of problems in other levels. All three surgeons who examined the patient did not pick up any neurological or vascular deficits or any significant problems within the joints of the lower extremities. None of the records indicate that there is any spondylolisthesis, retrolisthesis, or structural instability at the L4-5 level, except for some mild space narrowing. Therefore, it is determined that the proposed exploration laminectomy, posterior lateral fusion, bone graft iliac crest, and EBT bone stimulator are not medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5 (c))

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 11th day of September 2003.